Pain Physician. 2006;9:167-170, ISSN 1533-3159

Editorial

Cassandra's Curse: Interventional Pain Management, Policy and Preserving Meaning Against a Market Mentality

James Giordano, PhD

In Greek mythology, Cassandra was the most beautiful of King Priam's daughters. So striking was her beauty and demeanor that the god Apollo became smitten with her and bequeathed to her the gift of prophecy. But in exchange for his generosity, he sought to seduce her. Wishing to be virtuous, Cassandra refused. Apollo's retribution was to levy a curse upon Cassandra, such that all who heard her would be incredulous of her prophecies. The tragedy of Cassandra is that despite her prescience, she was rendered impotent to affect the future and avert calamity (1). The power of mythology is derived from the perdurability of meaning in metaphors that are relevant even in modern times. Thus, I pose the question - has interventional pain management suffered "Cassandra's curse"? For although scientific progress has led to an increased understanding of the mechanisms of pain and pain therapeutics, the administrative and economic infrastructure that fosters support (or lack thereof) for the provision of medical services are such that we are becoming ever more disempowered to use this knowledge to effectively care for those in pain.

From: Georgetown University Medical Center, Washington, D.C., and John P. McGovern MD Center for Health, Humanities and the Human Spirit, University of Texxas Health Sciences Center, Houston, TX
Address Correspondence: James Giordano, PhD, Scholar in Residence, Center for Clinical Bioethics, Georgetown University Medical Center, 4000 Reservoir Road, Washington, DC, 20057
Email: Gsynapse22.com
Disclaimer: There was no external funding in the preparation of this manuscript.
Conflict of Interest: None
Manuscript received on 6/30/06
Revision submitted on 7/3/06
Accepted for publication on 7/3/06

This paradox reflects the corporate systematization and commodification of medicine in general. As Laxmaiah Manchikanti (2) illustrates in this volume, economic corporatization of medicine is governmentally directed to subsidy agencies (namely Medicare and Medicaid) that ultimately influence, if not explicitly control, the climate of fiscal resource allocations manifested by other third-party payors. This has affected the practice of interventional pain management through a pervasive third-party focus upon proximate-cost containment that threatens the moral obligation to safely and effectively treat the pain patient. On a broader scale, this commodification is the result of numerous processes, including but not limited to a reciprocal interaction between a technological value-ladeness, Post-modern consumerist mindset and an imposing market-model mentality (3, 4).

I argue that ethical medical practice should not, and cannot be subsumed by an ethos of business (5). I base this argument upon the following premises: First, it is the ends, or telos, of any undertaking that establishes its nature, directs the ultimate focus of its activities, and often determines the conduct of those actions (6). The telos of business is profit; the telos of medicine is the beneficent and just provision of care to the patient (7-9). Thus, medicine is not business; and while there is an aspect of business within the practice of medicine, it is crucial to recognize that the act of medicine is dedicated by covenant to the good of the patient. Second, medicine is non-proprietary, and is not a public commodity to be restricted through market manipulation. As William F. May states, the covenantal fiduciary of medicine obligates respect of three fundamental features: 1) that medicine (as healthcare) is a fundamental, not instrumental good; 2) that it is not the only fundamental good, and as such must be efficient and cost-effective – not in the economic sense, but as moral imperatives against waste or injustice; and 3) that medicine is a public good (not a public commodity) and as such those who are involved in any domain of medicine bear the responsibility of public investment in that fundamental good (10).

Even if we were to concede that some aspect of medicine is a business, it is essential to recognize that any business exists to accommodate the needs of people, both individually and within community, and as such must reflect, and be sensitive to the values that support and determine those needs (11). Therefore, I opine that the corporate domain of medicine should be oriented and adherent to the moral values of those it serves. In other words, the "business of medicine" should be consistent with the ends, and uphold the moral values and obligations of medicine, rather than the moral affirmations and ends of medicine being deconstructed or bastardized to merge with those of business.

Both pain physician and pain patient place primary moral value upon the provision of right and good care that is engendered through the clinical encounter, and which reflects affirmation of and obligation to reciprocal trust, authenticity, and veracity (8, 12). Thus, patient and physician exist in community

– a relationship of shared values – that are focal to, and derived from the fact of pain, the physicians' act of profession and the nature and ends of medicine (9, 13). This community is bounded on one side by the needs of the patient for continuity of competent care and the empowerment of being healed, and on the other by the needs of the physician to be able to exercise knowledge and skill, sustaining medicine as a humanitarian healing endeavor. Within this community there is the expectation that what is offered is genuine, what is needed can and will be provided, and that the fiduciary will be upheld. Simply, the physician enters this community expecting that her professed skills, knowledge and abilities to engage the act(s) of medicine will be realized in the healing encounter, and the patient enters this relationship explicitly seeking the physician's competence and capacity for care. These expectations are not supererogatory, but rather reflect what Edmund Pellegrino calls the intrinsic premises of medicine qua medicine (14), and thus define what I believe to be the therapeutic and moral parameters of patient and physician de communitas – in fellowship. I argue that the "business of medicine" must support these values, enable these needs to be satisfied, and meet the expectations of the community it serves.

The disparate ends of business and medicine must be aligned such that the corporate and clinical components of medicine are mutually dedicated to the common end of rendering right and good care to patients. In this way, the 'business' of interventional pain management would afford the administrative and fiscal means to provide and sustain the medical resources required to best treat persons in pain. However, any strategy to accomplish this redirection cannot be myopic. Hence, while change is needed that must re-enable the clinician and empower the patient, any such change must also maintain some sense of economic viability in order to survive in a healthcare market that is not likely to be revamped in the proximate future (5). Manchikanti (2) has illustrated patterns and impact of Medicare reimbursement and procedure utilization, and shown that potential problems lie in the system of distributional resource allocation, its use, and the "downstream" effects incurred in the practice of interventional interventional pain management. But this is not simply "describing the curse", rather, Manchikanti (2) may be illuminating the course to effect a cure - by recognizing the nature, scope and magnitude of the problem we may establish a pediment to examining, identifying and ultimately developing effective and ethically sound solutions.

But we must be cautious, for complex problems cannot be solved by simple solutions. If we seek to revise Medicare, Medicaid and other third-party reimbursement systems, it is important to realize that simply enthusing available funding without implementation of guidelines and policy to guide use may incur potential dilemmas. There is evidence to suggest that augmenting support for particular maladies may actually increase their incidence and/or prevalence (15, 16). This "social iatrogenesis" can result from allocating resources toward therapeutic programs that 1) do not produce saliently positive end-goals, or 2) fail to recognize and implement new and novel approaches to treatment (17). Using even the most expanded resources in this way would be counter-productive, exacerbating the inadequacies of extant therapeutics, and thus do little more than fund the sick role. It is for these reasons that I maintain that the "cure for the curse" lies in a paradigm shift, the goal of which being economic and clinical programmatic revision(s) to enable care that is safe, effective and patient-focused, but not merely a perpetuation of existing services. To do this, it is important to thoroughly examine how support for particular services and procedures affects both physician use and patient outcomes. If we are to revise the third-party payment system, it must be a well-conceived revision, based upon evidentiary knowledge of what treatments work, what treatments do not, and why. But this would only be one factor amidst a larger tide of change.

By taking ardent, yet calculated strides toward change I believe that a lasting benefit of this Decade of Pain Control and Research would be the articulation of a new paradigm that engages truly translational research, encompassing the basic sciences, clinical applications, and social and economic analyses to compel development of guidelines and policy to support the delivery of the most effective pain therapeutics. From this, we may develop both improved methods of research and care, and modify fiscal resource allocations to allow subsidy of these enterprises.

But any venues to revision require subsidy. Without economically supported change, the system will continue its present spiral of commodification, resource restrictions, escalating costs and ineffectuality. Perhaps funding incentives generated by federally funded institutional programs (e.g.- National Institutes of Health, National Pain Care Policy Act, etc.) and distinct ear-marked governmental support at the local, state and national levels will establish subsidized resources for interventional pain management. These would be definitive steps in the right direction; but governmental articulation is slow, and change agency is not passive - it must be actively initiated, reinforced, and led through the strong voice of individuals in community (18). This can be achieved through the process of identifying purpose, developing plans and guidelines, and influencing progress as a result of interactive dialog. In this way, resultant policy would reflect and emphasize the values, serve the end(s), and ultimately enhance the substantive "goods" required to upbear the community of pain physician and patient. Within this paradigm, the clinical and corporate domains of medicine could become unified toward the development and delivery of more effective and ethically sound patient care.

References

1. Littleton CS. *Mythology: The Illustrated Anthology of World Myth and Storytelling*. London: Duncan-Baird Publishers, 2002.
2. Manchikanti, L. Medicare in interventional pain management: A critical analysis. *Pain Physician*, 200:9:171-197

3. Giordano J, Hutchison PJ. Regrounding medicine in humanity amidst technocracy and cultural pluralism. Paper presented at the Roundtable in Arts and Sciences, University of Oxford, Oxford, UK, 10. July, 2006.

4. Grenz SJ. *A Primer on Postmodernism*. Cambridge, WD Eerdmanns Press, 1996.

5. Giordano J. Interventional pain management, morality and the marketplace: Time for a change. *Prac. Pain Management* 2006; 6(1): 88-89.

6. Aristotle. *The Nicomachean Ethics.* Book I, Ch. 1, Irwin T. (trans.), Indianapolis, Hackett Publishing, 1999 pp.1-2.

7. Klein S. An Aristotelian view of theory and practice in business ethics. *Int. J. of Applied Philosophy,* 1998 12 (2): 203-222.

8. Pellegrino ED. The healing relationship; Architectonics of clinical medicine. In: Shelp EE (ed) *The Clinical Encounter: The Moral Fabric of the Physician-Patient Relationship.* Boston, Reidel, 1983.

9. Pellegrino ED. The anatomy of clinical judgments: some notes on right reason and right action. In: Engelhardt HT, Spicker SF, Towers B. (eds.) *Clinical Judgment: A Critical Appraisal.* Dordrecht, Reidel, 1979; pp. 169-194.

10. May WF. *The Physician's Covenant.* Revised edition. Philadelphia, Westminster Press, 2000.

11. Gini A. Moral leadership: an overview. *J. Business Ethics,* 1997 16(3): 323-330.

12. Giordano J. Moral agency in interventional pain management: philosophy, practice and virtue. *Pain Physician* 2006; 9: 71-76.

13. Giordano J. Toward a core philosophy and virtue-based ethics of interventional pain management. *Pain Practitioner,* 2005. 15(2): 59-66.

14. Pellegrino ED. Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. *J. Med. Philosophy* 1979; 4(1): 32-56.

15. Payer L, *Medicine and Culture.* NY, Owl Books, 1996.

16. Herzlich C. Modern medicine and the quest for meaning: Illness as a social signifier. In: Auge M, Herzlich C (eds.) *The Meaning of Illness.* Luxembourg, Harwood Academic Publishers, 1995, pp. 151-174.

17. Illich I. Medical Nemesis: *The Expropriation of Health.* NY, Pantheon, 1976.

18. Bass BM, Steidlmeier P. Ethics, character and authentic transformational leadership behavior. In: Ciulla JB (ed.) E*thics, the Heart of Leadership.* Westport, CT, Praeger, 2004, pp.175-196.